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ABSTRACT

Research on interpersonal influence within counseling psychology has focused primarily on the characteristics of the counselor. There is a need to study the role of client characteristics in resistance or noncompliance. A review of the literature indicates that most client characteristics associated with noncompliance in therapy can be narrowed into five major categories. One type of noncompliance relates to a client's lack of cognitive, interpersonal, or behavioral skills that may limit potential ability to deal with counselor requests. Another variable is client expectations concerning the effectiveness and length of treatment. A third variable which may be related to both maintaining problem behavior and developing new coping responses is the client's support system. Certain fixed modes of thinking or behaving with which clients begin therapy appear particularly resistant to change and may help them defend against having to cope successfully. And finally, demographic variables such as social class also can influence clients' resistance. The unique skills and abilities which the client brings into the counseling relationship represent two broad categories: intrapersonal skills, mobilized to enhance one's sense of self-efficacy and mastery; and interpersonal skills, used in interacting with others. Both inter- and intrapersonal skills are needed to prevent a stressful event, limit an event in progress, or adjust to the effects of the event. Treatment compliance will be enhanced if the counselor is aware of the client's level of coping and the skills the client needs to enjoy a sense of mastery and competence. (JAC)

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Client Resources: Client Characteristics, Coping Skills, and Compliance

Kathryn A. Govaerts and Douglas H. Olson

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Running head: Client Resources

This paper was presented at a symposium on Resistance and Treatment Compliance: A Social Psychological Analysis at the 1983 American Psychological Association Convention, Anaheim, California. Both of the authors are doctoral students in counseling psychology at the University of Nebraska-Lincoln.

Our goal for this first segment of the symposium is to discuss some of the important characteristics the client brings to the counseling interview. Recognizing that there are three main influences to be considered in counseling (the counselor, the client, and the interaction) we will extract one portion of this conceptualization for our discussion. That portion is client characteristics. However, we are acutely aware that client characteristics are interacting with and being influenced by the other variables contributed by counselor characteristics and the interaction itself.

Our focus will be on client characteristics that are importantly related to compliance/non-compliance to treatment efforts. From his analyses of the literature available on resistance, Doug will describe major categories of client characteristics related to resistance. Kathy, will then narrow the focus to certain abilities and skills the client uses to deal with life's vicissitudes stressing the multidimensional nature of coping and the abilities required to do so effectively.

Part 1: Client Characteristics and Compliance

Recent articles (Heppner & Dixon, 1981; Heppner & Heesacker, 1983) indicated that much of the interpersonal influence research within counseling psychology has focused primarily on the characteristics of the counselor (i.e., expertness research, etc.). These authors note that research investigating the effects of client characteristics as a major variable in counseling, has been

noticeably lacking, and should be the focus of research in the future.

The need to study the role that client characteristics play in counseling becomes quite apparent to the researcher interested in the phenomenan of resistance or noncompliance. Despite the fact that the interpersonal influence literature in counseling has not focused on client characteristics, much can be learned about client variables and noncompliance by reviewing the resistance literature available across theoretical perspectives.

The results of client characteristics studies which are scattered throughout the resistance literature, indicate some general patterns across theoretical perspectives. Most of the client characteristics associated with noncompliance in therapy can be narrowed down into five major categories. These categories are: (a) client abilities and skills, (b) expectations, (c) environmental supports, (d) general modes of thinking and behaving, and (e) demographic variables. To different degrees, clients all enter therapy with variables which pertain to the five categories. Results from the various studies on client characteristics and noncompliance will now be discussed according to this organizational scheme.

Client Abilities and Skills

Munjack and Oziel (1978) have categorized resistance encountered in sex and marital therapy into five types. Type 1 resistance is the result of a lack of understanding by the client as to what is supposed to be done. Resistance due to a client's deficits in skills is Type 2. Type 3 resistance arises from a lack of motivation or

expectations for success. Resistance due to the client's anxiety or guilt is Type 4. Finally, Type 5 resistance is due to secondary gain which maintains symptoms. Of the five types of resistance described by Munjack and Oziel (1978), Type 2 resistance is the most relevant to our client characteristics category of "abilities and skills." In Type 2 resistance, the client may understand the communication of the counselor and would probably implement the suggestion, if only the client had the prerequisite skills needed to follow through with the request. Other authors (Jahn & Lichstein, 1980; Stuart, 1980; Turkat & Meyer, 1982) support this contention that noncompliance may result because the client has specific skill deficits.

Two studies (Baekland & Lundwall, 1975; Heilbrun, 1982) have cited noncompliance, at times, as being a result of deficiencies in a client's cognitive and interpersonal abilities. Goldstein, Heller, and Sechrest (1966) indicated that poor cognitive ability on the part of the client may prevent grasping the full intent of a communicator's remarks. Bandura (1982) emphasized the important role of the client's sense of self-efficacy, which influences how they regulate events in their lives. Self-efficacy is explained as involving a generative capability in which component cognitive, social, and behavioral skills must be integrated into courses of action to deal with situations which arise. It may be implied from Bandura's concept of self-efficacy that a client who is lacking in cognitive, social, and/or behavioral skills may lack confidence in an ability to execute appropriate courses of action in problem situations. Those client's with serious doubts about their

capabilities would be inclined to give up more easily in the face of obstacles.

Several studies (Cowan, Hoddinott, & Wright, 1965; Goldstein, Heller, & Sechrest, 1966; Lazarus & Fay, 1982) have made an important distinction between "deliberate" resistance on the part of the client versus resistance due to "deficiencies" in abilities. Deliberate resistance can be conceptualized as negativism or motivation not to do what is requested. It is an active type of resistance that entails a conscious effort on the part of the client not to comply. However, noncompliance due to deficits in abilities may be a more unconscious resistance due to lack of capacity, lack of experience with skills, poor cognitive ability, poor verbal ability, and deficiencies in interpersonal abilities. The end result of both forms of resistance is that they result in noncompliance to treatment efforts in most cases. These studies imply that we should be careful not to suspect deliberate noncompliance too quickly and that the distinction should be made as to whether a client is unable to comply or unwilling to comply.

Client Expectations

It has long been believed that clients enter counseling with certain expectations which may have an important influence on counseling process and outcome (Frank, 1959; Goldstein, 1962). Lorion (1974) concluded that the course of treatment is critically shaped by the patient's expectations about therapy.

As was mentioned earlier, Munjack and Oziel (1978) identified poor expectations or little hope of positive change on the part of

the client, as one major type of resistance in therapy (type 3 resistance). The lack of positive expectations of success may result from such things as: a previous lack of success with other therapist or failure of self-help treatments (Marston & Feldman, 1972; Munjack & Oziel, 1978).

Some studies have shown a relationship between clients' expectations concerning therapy and the longevity of treatment (Baekland & Lundwall, 1975; Heine & Trosman, 1960; Overall & Aronson, 1962). These studies provided some support for the contention that a client receiving treatment which is incongruent with prior expectations regarding treatment, is more likely to be dissatisfied and more apt to withdraw from therapy.

Tinsley, Workman, and Kass (1980) utilized an "Expectations About Counseling" questionnaire to measure the expectancies a prospective client might have about counseling. The EAC consisted of 135 items comprising 17 client expectancies about counseling. Each item was prefaced with "I expect to" or "I expect the counselor to" and was presented in a Likert format. Due to growing discontent with expectation research, Tinsely, Workman, and Kass (1980) presented some guidelines for future systematic research. These guidelines included measuring all aspects of clients' expectations about counseling, documenting the reliability of the scales used in measuring client expectancies, and methods of analysis which are defensible should be used.

Using these guidelines as a model, Tinsley, Workman, and Kass (1980) performed a factor analysis on scores obtained from the EAC

questionnaire to examine the dimensions underlying a broad range of client expectancies for counseling. They found 3 major factors underlying client expectancies. The factor accounting for the most variance in client expectancies was Personal Commitment about counseling. It was predicted that subsequent research would find that moderately high scores on the Personal Commitment factor would be a good prognostic sign for such things as following through with assignments and continuation in therapy. A second factor obtained was client expectancies that the counselor Facilitative Conditions would be present. These are expectations that the counselor would be genuine, trustworthy, accepting, and tolerant. The authors hypothesized that moderately high scores on the Facilitative Conditions expectancy factor, would prove to be a good prognostic sign, provided the expectancy is consistent with the counselor's personal style of counseling. The third factor obtained was the expectancy that the counselor would be an Expert. The three major expectancy factors may be of great practical significance. However, more research is needed to investigate and verify the existence of the factors identified by these authors which may underlie client expectancies for counseling.

Despite the contentions made about the relationship of client expectations to compliance, the overall findings have been clouded by the lack of systematic studies which define and measure expectations carefully. In line with the frustrations that Tinsley, Workman, and Kass (1980) experienced in their review of the studies on expectations, Duckro, Beal, and George (1979) and Garfield (1978)

concluded that the definitions of "expectation" and the subsequent use of the term makes expectancy research ambiguous and difficult to interpret.

Goldstein (1962) identified two major categories of expectations that might be studied in counseling research. With regards to a generalized client expectancy, one type was identified as prognostic expectations, which are prior beliefs regarding the probability of success in counseling. The other type is participant role expectations. It is evident that more systematic research is needed which carefully defines and measures client expectations to determine the role they play in compliance.

Environmental Supports

The client's environmental network may be effective in either influencing compliance to treatment or conversely in the reinforcing of problem symptoms, thus making the client more resistant to treatment efforts. Until recently, very little attention has been paid to the resistance which may be engendered by the client's social support system (Jahn & Lichstein, 1980). However, evidence is growing that social support (particularly support provided by the patient's family) plays an important role towards influencing compliance (Becker & Maiman, 1980).

Munjack and Oziel (1978) list one type of resistance as due to positive reinforcement or secondary gain which supports the problem behavior. The authors indicated that gains for symptoms can be substantial and may be as diverse as monetary gain, the avoidance of work or stress, attention or sympathy, continuing visits to the

therapist, and relationship gains or rewards as a result of maintaining symptoms.

In dealing with resistance, Lazarus and Fay (1982) indicated that it is important to consider who or what may be maintaining the behavior. These authors commented that many patients receive intermittent reinforcement from significant others who deliberately or inadvertently foster the symptoms. Thus, the client's support system may often undermine a therapist's efforts, when there is a fear that a change in an individual will threaten the security of others in the support system. Thus, family therapy may become an important medium in offsetting these sources of resistance. Lazarus and Fay (1982) stated that,

> Individuals influence and are influenced by the people with whom they come in contact (especially relatives and friends), and hence a change in one person is likely to have repercussions on significant others. If a positive change in an individual is inclined to have a negative impact on someone else in his/her network, some form of reluctance or resistance to change may be forseen . . . some member of the family or social network will probably find a way of preserving the status quo. Being alert to these interactive processes is often a sine qua non for therapeutic success (p. 128).

Modes of Thinking/Behaving

A client's fixed patterns of thinking and/or behaving in problem situations appears to be closely related to noncompliance.

Zucker (1967) indicated that one condition of resistance is the "tenacity of character" which refers to long standing, maladaptive traits or habits. By "tenacity of character" the author asserts that forces exist that tend to stamp in and brace traits of character which, in turn, make ability to change maladaptive ways of dealing with problems a highly difficult endeavor. Associated with this "fixity" of character is the fear that a client has of incorporating things that are new, different, or unknown to them.

Characteristic modes of thinking or behaving, and their relation to noncompliance, can be viewed across theoretical persuasions. The labels given for this client characteristic, change from one theorist to another but, the concept remains similar. For example, one of the basic assumptions of cognitive dissonance theory (Festinger, 1957) is the tendency towards maintaining consistency among cognitions about oneself and the environment. Frank (1973) called this consistency tendency and the clients' organized body of beliefs about the world, the "assumptive world" of the client. Resistance has also been spoken of in terms of the ease with which the patient will accept alternate "constructions" of events, other than the one the person is maintaining (Levy, 1963). Furthermore, Fenichel (1945) discussed the difficulty a therapist has in handling "character resistances" that are related to characteristic attitudes a client has developed over time to defend against having to deal with problems consciously. Finally, Goldstein (1959) studied subjects responses to tension-arousing stimuli by looking at their "characteristic modes of responding" to such stimuli.

Dabbs (1964) hypothesized that subjects would be expected to resist influence of a particular communication whose content was incomparable with their "characteristic mode of defense." Similarly, Blatt and Erlich (1982) viewed resistance as a natural consequence of the transaction between distortions in patient's "mode of relatedness" and the therapist's therapeutic style and skill.

Despite the fact that all of these modes, tendencies, characteristics, and traits appear to be looking at the same basic concept, they are based on theoretical premises that lack clear operational definitions. However, given the consensus across many theoretical perspectives that general modes of thinking/behaving are closely related to reluctance to change, this area of study warrants further systematic research.

Demographic and Other Client Variables

Client variables such as social class, age, sex, personality variables, education, and intelligence have been studied in an attempt to find consistent characteristics which may predict therapy dropout and outcome. It has been found that social class index (i.e., Hollingshead social class index) is generally a good predictor of acceptance into and duration of therapy (Cole, Branch, & Allison, 1962; Lorion, 1973). However, it is important to note that therapists have a tendency to prefer upper class clients who may be similar in many ways to the therapist (Schofield, 1964). Such values held by the therapist might interact with characteristics the client brings to therapy, thus influencing acceptance and duration. Although social class seems to have predictive value for

for potential outcome of therapy appears limited (Lorion, 1973; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971).

Age and sex of clients do not appear to be important variables in predicting either premature termination (Afflect & Garfield, 1961; Garfield & Afflect, 1959; Rosenthal & Frank, 1958) or outcome of therapy (Garfield, 1978).

Although the findings appear mixed, education level may also be an important factor in predicting premature termination (Rosenthal & Frank, 1958), as well as the outcome of therapy (Garfield, 1978). Similarly, results are mixed with regards to the relationship between intelligence and outcome. Some possible implications for both the education and intelligence variables were posited by Meltzoff and Kornreich (1970) in a literature review, which indicated that high intelligence is not a necessary condition for successful therapy, even though it may be more important in some therapies than others.

Psychiatric diagnosis does not appear to be related closely to therapy dropout or continuation in therapy (Afflect & Garfield, 1961; Garfield & Afflect, 1959; Rosenthal & Frank, 1958). In a comprehensive review of research on client variables in psychotherapy, Garfield (1978) concluded that it is difficult to draw inferences from findings on personality variables due to inconsistencies in study methodology. Some of the problems cited were associated with measuring devices, constructs used, type of therapy, and variations in outcome criteria utilized by studies.

Summary and Discussion

Five major categories of client characteristics have been identified in this paper which may be used as a guide by the researcher or clinician in predicting potential noncompliance. These characteristics are all present in some form before, during, and following counseling.

One type of noncompliance that has been identified is due to a lack of client skills or abilities to follow through with treatment suggestions. A client's lack of cognitive, interpersonal, or behavioral skills may limit potential ability to comply with certain requests of the therapist and the demands of various therapies which tailor to clients with high ability levels. The ability to screen clients' for ability and skill deficiencies prior to therapy, would seem to be a promising way to predict those clients who may be unable to comply.

Another variable that may be related to compliance is client expectations. It would be helpful for researchers and clinicians to obtain some evidence prior to therapy about a client's perceived success with past therapists, therapeutic methods, and self-help techniques. Client expectations appear to be a good predictor of duration of stay in therapy. More studies are needed to examine the possible result of congruence/incongruence between clients' prior expectations regarding treatment and actual treatment received. In addition, more systematic research might be of value which operationally defines and reliably measures expectations, to eliminate current ambiguous findings.

Counseling research or practice which does not take into account the environmental support system of the client, may be negligent in examining a variable which may be importantly related to both maintaining problem behavior and developing new coping responses. Assessment is needed, prior to and during counseling, of environmental stimuli that may be providing reinforcement for symptoms. Also, analysis is needed of possible environmental supports which may be possible resources for a particular client in the generalization of treatment from the clinic to the natural environment.

Certain fixed modes of thinking or behaving that clients' begin therapy with, appear particularly resistant to change and may help them defend against having to cope successfully. It might be helpful for researchers to integrate the scattered findings in this area, into a cross-theoretical understanding of the phenomenon. It would seem that entrenched modes of thinking and behaving lend themselves well to research into interpretations and behavior change which attempt to assess prior ways of thinking/behaving, administer discrepant ways of coping, and then measure the subsequent change in behavior.

With regards to demographic variables, social class index (i.e., Hollingshead) appears to be a promising predictor for longevity of therapy. However, the values that therapists hold with regards to ideal clients may confound this finding. The predictive value of education and intelligence appears to be mixed but, they may play an important role depending on the type of therapy offered.

More systematic research is needed to identify other relevant demographic and personality variables related to compliance.

As has been previously stated, a majority of the research on the interpersonal influence process in counseling has centered on counselor characteristics. A need for more studies to examine the role of client characteristics is evident, especially with regards to studying noncompliance. Perhaps, part of the reason that the role of client characteristics and noncompliance has not been studied extensively in interpersonal influence research, that is, resistant clients are usually less willing subjects in psychological research and are thus less readily available for study (Goldstein, Heller, & Sechrest, 1966). In the Corrigan, Dell, Lewis, and Schmidt (1980) review of research on counselor characteristics, 70 studies were examined to assess the interpersonal influence process posited to be occurring in counseling. Studies were extracted from 10 different journals, all of which were published between 1968 and 1979. Of those reviewed, 59 out of 70 studies utilized college students as subjects. To enhance external validity of findings, and to gain a better understanding of resistance, it is hoped that in the future a variety of treatment settings and subject populations might be utilized in interpersonal influence studies.

In the next presentation, Kathy will focus on client coping skills and various methods that might be used to teach ways of coping more effectively.

Part 2: Coping Skills and Abilities

While the client brings his or her own unique set of skills and abilities to the counseling relationship, it is reasonable to think of those skills as representing two broad categories. One category is composed of intrapersonal skills. These skills are intrapsychic, private, and occur within the person. It is my hypothesis that these skills are mobilized to enhance one's sense of self efficacy and mastry. The second category of skills are the interpersonal ones. These abilities are used in interacting with others and are more public in nature. It is my hypothesis that the goal of these skills is to convey an impression of competence to those in the social environment.

Gratefully not all of life's problems are of the same magnitude and duration. Some are more minor, the "daily hassels and uplifts" described by Kanner, Coyne, Schaeger, and Lazarus (1981). Other problems are of major importance and impact. Examples here include transitions (Brammer and Abrego, 1981), severe illness (Moos, 1979), and impending death (Kubler-Ross, 1969). Therefore, in addition to needing both inter- and intrapersonal coping skills, one also needs a repertoire of skills for problems of varying magnitude and duration. Therefore, my hypothesis is that both intra- and interpersonal skills are needed (a) to prevent a stressful event from happening, (b) to decrease the magnitude and duration of an event in progress, and (c) to cope with the event's sequelae in ways that allow one to recuperate from or adjust to the change.

Coping Skills for Prevention of an Event

Let us first look at the intrapersonal skills that may be mobilized in response to a perceived future threat with the goal of preventing its occurrence. Problem solving models as suggested by Mahoney's "personal SCIENCE" (1977) and Goldfried and D'Zurilla's behavioral model (1969) are examples of skills that fit into this category. In general, problem solving skills require the ability to specify the problem, collect information about its causes and solutions, name and narrow various options, and finally choose a course of action. The models also include an evaluation step that compares results to goals. A related skill is appraising minor events (Coyne, Aldwin, & Lazarus, 1981) and involves utilizing the ongoing, cognitive process that makes an appraisal of the event's significance to the client's well being. Secondary appraisal processes lead the client to discover what can be done about the situation. Janis and Mann's model (1977) of vigilant coping also fits well here and will be discussed in greater detail in a later presentation.

Rehearsal is another intrapersonal skill useful in preventing an undesired amount of stress from occurring. The stress inoculation techniques of Meichenbaum (1980) and covert modeling described by Spiegler, Liebert, McMains, and Fernandez (1969) provide ways the client can systematically imagine the event, mentally prepare for it, cope with and prevent an escalation of negative feelings, and reward himself for having coped.

As essential as intrapersonal coping skills are, Pearlin (1981) writes that they must be coupled with social support to effectively regulate stress. Similarly, Justice and Swensen (1980) report that social assets correlate significantly with psychological functioning, interpersonal involvement with friends and family, and productivity in general. There is an inverse relationship between social support and anxiety, rating of life change events, and psychological distress (Halahan & Moos, 1981). Gerald Caplan (1981) also emphasizes the importance of the ability to elicit social and environmental support. Because in a crisis people frequently suffer from an erosion of cognitive abilities, one needs to be able to ask for and receive more information. Further, one needs better ways to gather and evaluate information as well as plan for action. Additionally, the environmental support system is helpful in maintaining an identity as a successful coper. The social network supplements the very areas weakened by the anticipation of the stressful event. Such support can be instrumental in helping the individual tolerate more stress and to persevere inspite of it. Examples of coping in the presence of supportive others include the Outward Bound exercises, battle training, and preparation for certain medical procedures.

Coping Skills for Limiting an Event in Progress

Once the event is in progress the previous intrapersonal skills are still useful, and some additional ones may be enlisted to enhance one's sense of mastry. One such strategy which we will call "renaming" has been described by Pyszczynski (1982) and Pearlin (1981). In the case of an event already in progress, the client may

seek to control the amount of stress or disappointment that accompanies a very desirable but unattainable outcome. Pyszczynski's subjects saw the outcome of winning a very valued prize as less desirable when the liklihood of winning was low. Similarly Pearlin's subjects compared themselves in an economically positive way with others to control the amount of stress accompanying concerns about money. Interestingly this comparison involved both other people and time. Renaming is also used to change the valence of economic achievement making a lack of money and the accompanying deprivations less important.

A great deal of work that describes client skills once a stressful event is in progress has to do with limiting smoking and eating behaviors. Schacter (1982) stresses the importance of perseverance and the ability to see quiting or loosing as a process of small steps rather than as a one time event. Perri and Richards (1977) say the successful coper uses a greater variety of techniques for longer periods of time, uses more positive self reinforcement, and adapts the coping skill to the particular problem. Rozensky and Bellack (1974) report that quiters/losers use significantly more meaningful positive self reinforcement.

When the client is experiencing a particularly stressful event, we know that certain intrapsychic defenses such as denial, selective inattention, isolation, and withdrawal may be operative as rather unsuccessful attempts to increase the individual's comfort. However, this is an incomplete solution and once again the interpersonal coping skills are needed. The task of those in the client's social

support system is to help limit the emotional arousal and dysphoria that accompanies a stressful event. Further, others will help the individual to see beyond the immediate wish for comfort to some integration of the events into his/her ongoing life (Caplan, 1981). Friends and family may need to exercise appropriate surveillance while allowing the client to sufficiently relax the defenses so that confrontation of the unpleasant situation may begin. Others may do a number of things to lower the client's anxiety while still demonstrating concern about the stressful situation. Examples include validating the client's ideas about the degree of threat and its consequences, distracting, nurturing, and dissapating shame and guilt. Caplan (1981) reminds the counselor of the power of behavior contagion in both positive and negative ways during this particularly susceptible period.

Coping Skills for the Sequelae of an Event

The third set of skills I wish to explore are those that the client needs to cope with the sequelae of a stressful event. Once again we will look at both inter- and intrapersonal skills and abilities. Much of the material in this third category has to do with major life events such as serious illness, transitions, and death.

Using specific intrapersonal techniques may prove helpful in ameliorating the effects of an especially stressful event. Gallagher and Thompson (1982) report on a one year follow up of 27 clients who were diagnosed as depressed. This group had received 16 sessions of either cognitive, behavior, or relationship therapy. Eighty-nine

percent of those in the cognitive and behavioral groups reported being symptom free. All acknowledged the occurrence of stressful events during the follow up period, but they used the specific intrapersonal techniques of tracking pleasant events and mood monitoring as ways to deal with unpleasant situations. The authors felt there was a high relationship between improvement and specific skill usage.

Using crisis theory Moos (1977) describes the intrapersonal coping skills needed to cope with a life threatening illness. Included are the skills that are used to deny or minimize the seriousness of the illness, its significance, or its potential consequences. This initial coping style gives the client time to absorb the enormity of the situation. A useful and related skill is the ability to deal with some aspects of the crisis in an emotionally neutral way. Another set of coping skills mobilizes information seeking activity about the illness, its treatments, and outcomes. Knowing more may well increase a sense of competence and has some anticipatory coping value, too. A third set of coping skills involves active efforts to master specific procedures related to the illness. Once again this type of coping is an effort to increase the sense of competence and to make the illness manageable at least in some areas. A fourth group of skills centers on maintaining regular routines and setting achieveable goals. This may mean dressing in street clothes or walking a few steps after a stroke. Still other client efforts seek to find a meaning or purpose

for the illness. This search is often made in the context of the client's religious beliefs.

The work of Brammer and Abrego (1981) describes both inter- and intrapersonal skills useful in major life transitions. The authors believe that skills to cope with losses in one stage will be invaluable in managing future transitions. The familiar stages of coping with a loss will provide a stimulus for the development of individualized coping skills. In stage one, shock and immobilization, the client needs to be able to ask for and receive the support of significant others. This support may vary from short visits with a sympathetic relative to long-term treatment by a mental-health professional. Denial, stage two, has a cushioning effect similar to that described in coping with illness and impending death. An important intrapersonal skill, then, is the ability to discriminate between when to deny and when to meet the challenge head on. During the third stage, depression, an intense sadness replaces the emotional void of denial. The coping skills now include cognitive manipulation that emphasizes pleasant events or memories and stops the unpleasant ones. In stage four, letting go, coping may be cognitive (i.e., decide to change, to adapt), emotional (saddness and anger), or a combination of both. Stage five involves testing options, and it begins once the awareness of the loss becomes intensified. Two productive coping skills here are information seeking and assimilation of the knowledge generated. A search for meaning involves using more and more cognitive reflections in an attempt to identify the positive learning gained. The final step, integration, requires the

reframing of assumptions and values and initiating new behaviors. New hope is generated that what has been gained in this transition may later be applied to new ones.

Kubler-Ross (1969) describes five steps that may also be considered as useful abilities in dealing with death, either of oneself or a loved one. These stages are similar to those described by Moos (1979) in coping with a serious illness and by Brammer and Abrego (1981) in coping with transitions. Again in the first stage denial and insulation are useful buffers to gain time to mobilize other more active defenses. In the second stage, anger is displaced in all directions. Very little is pleasing to the client, and it is an especially time for others. Helping the client to see some of the reasons for the anger is an important contribution to passing through this stage. Bargaining takes place in stage three and represents a shift to nearly opposite types of behavior. If anger was not productive perhaps, the client reasons, exceptionally good behavior will have its reward. In stage four the anger and rage are replaced with a sense of past and impending loss. A useful coping skill here is the expression of the sense of loss contributing to the depression. Acceptance marks the fifth stage. The client is no longer depressed or angry, but neither is he or she happy. The impending loss is mourned, but the end is contemplated with a certain amount of quiet submission. The client appears more and more detached with a decreasing range and magnitude of feelings. In the acceptance stage, the counselor will respect the client's wishes to

limit involvement with the present world and help the survivors recognize the importance of detachment.

Caplan (1981) also stresses coming to terms with an event and the sequelae it generates by the process of personal readjustment. In the event of death, much readjustment is facilitated by societal customs and a supportive social network that allows grief and anger to emerge despite the individual's pain and reluctance to fully experience these emotions. At this stage there is a need for long acting and preferably from family and community, social support.

The use of interpersonal coping skills as strategies to deal with the sequelae of stressful events is also found in work by Hirsch (1980) and Schaefer, Coyne, and Lazarus (1981). The latter authors studied the characteristics of social support networks and agreed that the size or density was independent from the amount and type of perceived social support. Studying 100 middle aged adults for one year, Schaefer, Coyne, and Lazarus (1981) found that low tangible and emotional support were related to negative morale. High informational support was associated with positive morale. The importance of cognitive guidance was reiterated by Hirsch (1980) in the study of young widows and nontraditional undergraduate students. The subjects in this study identified asking for and receiving cognitive guidance as their single most important coping skill. Certainly one implication for the counselor is teaching effectively to elicit such cognitive help.

Summary

In summary, I have hypothesized that each individual brings to the counseling interview a unique set of skills and abilities that are both intra- and interpersonal in nature. The former are mobilized to increase the individual's sense of efficacy and mastry. The latter are used to convey a sense of competence to the world in which the client must live. I further hypothesize that treatment compliance will be enhanced if the counselor is clear about the level on which coping is taking place and the intra- and interpersonal skills the client needs in order to enjoy a sense of mastry and competence.

A number of studies were reviewed that described a variety of intrapersonal skills that aid the client in preventing an event's occurrence, lessening the stress generated by an event already in progress, and finally coping with the results of a stressful event. These studies demonstrated considerable breadth in strategies as well as populations studied. Certainly there is always a need for specific interventions to be studied for specific problems and populations.

Fewer studies were presented that described the ways in which a distressed person can request and receive assistance from his/her social support system. Areas of future interest might include (a) ways the client can best request and receive assistance from others in a variety of situations and over time and (b) the kinds of interpersonal interventions most useful for each of the three levels of coping noting differences between utilizing primary and community

support networks. I acknowledge that adding other people to the counseling equation greatly complicates its study and adds variables whose measurement demands great creativity. However, because one of the counseling's primary goals is to improve the client's functioning in his/her own environment, the study of the individual in that milieu is fundamental.

References

Afflect, D. C., & Garfield, S. L. Predictive judgements of therapists and duration of stay in psychotherapy. Journal of Clinical Psychology, 1961, 17, 134-137.

Baekeland, F., & Lundwall, L. Dropping out of treatment: A critical review. Psychological Bulletin, 1975, 82, 738-783.

Bandura, A. Self-efficacy mechanism in human agency. American Psychologist, 1982, 37(2), 122-147.

Becker, M. H., & Maiman, L. A. Strategies for enhancing patient compliance. Journal of Community Health, 1980, 6(2), 113-134.

Blatt, S. J., & Erlich, H. S. Levels of resistance in the psychotherapeutic process. In P. L. Wachtel (Ed.), Resistance: Psychodynamics and behavioral approaches. Plenum, 1982.

Brammer, L. M., & Abrego, P. J. Intervention strategies for coping with transitions. The Counseling Psychologist, 1981, 9, 19-36.

Caplan, G. Mastery of stress: Psychosocial aspects. American Journal of Psychiatry, 1981, 138(4), 413.

Cole, N. J., Branch, C. H., & Allison, R. B. Some relationships between social class and the practice of dynamic psychotherapy. American Journal of Psychiatry, 1962, 118, 1004-1012.

Corrigan, J. D., Dell, D. M., Lewis, K. N., & Schmidt, L. D. Counseling as a social influence process: A review. Journal of Counseling Psychology Monograph, 1980, 395-441.

Cowan, P. A., Hoddinott, B. A., & Wright, B. A. Compliance and resistance in the conditioning of autistic children: An

exploratory study. Child Development, 1965, 36, 913-923.

Coyne, J. C., Aldwin, C., & Lazarus, R. S. Depression and coping in stressful episodes. Journal of Abnormal Psychology, 1981, 90, 439-447.

Dabbs, J. M. Self-esteem, communicator characteristics, and attitude change. Journal of Abnormal and Social Psychology, 1964, 69(2), 173-181.

Duckro, P., Beal, D., & George, C. Research on the effects of discomfirmed client role expectations in psychotherapy: A critical review. Psychological Bulletin, 1979, 86, 260-275.

Fenichel, O. The psychoanalytic theory of neurosis. New York: W. W. Norton & Company, Inc., 1945.

Festinger, L. A theory of cognitive dissonance. Evanston, Ill.: Row Peterson, 1957.

Frank, J. D. The dynamics of the psychotherapeutic relationship. Psychiatry, 1959, 22, 17-39.

Frank, J. D. Persuasion and healing (Rev. ed.). Baltimore, Md.: John Hopkins University Press, 1973.

Gallagher, D., & Thompson, L. Stressful events, coping and relapse rates in depressed elderly. Paper presented at the Nineteenth Annual Conference of the American Psychological Association, Washington, D. C., August, 1982.

Garfield, S. L. Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis (2nd ed.). New York: Wiley, 1978.

Garfield, S. L., & Afflect, D. C. An appraisal of duration of stay in outpatient psychotherapy. Journal of Nervous and Mental Disease, 1959, 129, 492-498.

Goldfried, M., & D'Zurilla, T. J. A behavioral-analytic model for assessing competence. In C. D. Spielberger (Ed.), Current topics in clinical and community psychology (Vol. 1). New York: Academic Press, 1969.

Goldstein, M. J. The relationship between coping and avoiding behavior and response to fear arousing propaganda. Journal of Abnormal and Social Psychology, 1959, 58, 247-252.

Goldstein, A. P. Therapist-patient expectancies in psychotherapy. New York: Pergamon Press, 1962.

Goldstein, A. P., Heller, K., & Sechrest, L. B. Psychotherapy and the psychology of behavior change. New York: John Wiley & Sons, Inc., 1966.

Halahan, C., & Moos, R. Social support and medical distress: A longitudinal analysis. Journal of Abnormal Psychology, 1981, 90(4), 365-370.

Heilbrun, A. B. Cognitive factors in early counseling termination: Social insight and level of defensiveness. Journal of Counseling Psychology, 1982, 29(1), 29-38.

Heine, R. W., & Trosman, H. Initial expectations of the doctor-patient interaction as a factor in continuance in psychotherapy. Psychiatry, 1960, 23, 275-278.

Heppner, P., & Dixon, D. A review of the interpersonal influence in counseling. Personnel and Guidance Journal, 1981, 59, 542-550.

Heppner, P. P., & Heesacker, M. Perceived counselor characteristics, client expectations, and client satisfaction with counseling. Journal of Counseling Psychology, 1983, 30(1), 31-39.

Hirsch, B. Natural support systems and coping with major life changes. American Journal of Community Medicine, 1980, 8, 159-172.

Jahn, D. L., & Lichstein, K. L. The resistive client: A neglected phenomenon in behavior therapy. Behavior Modification, 1980, 303-320.

Janis, I. L., & Mann, L. Decision making: A psychological analysis of conflict, choice and commitment. New York: The Free Press, 1977.

Justice, B., & Swenson, K. Social assets and personal and social functioning. The Journal of Psychology, 1980, 106, 277-286.

Kanner, A., Coyne, J., Schaefer, C., & Lazarus, R. Daily hassles and uplifts vs. major life events. Journal of Behavioral Medicine, 1981, 4(1), 1-39.

Kubler-Ross, E. On death and dying. New York: The Macmillan Publishing Company, Inc., 1969.

Lazarus, A. A., & Fay, A. Resistance or rationalization? A cognitive-behavioral perspective. In P. L. Wachtel (Ed.), Resistance: Psychodynamic and behavioral approaches. Plenum Press, 1982, 115-132.

Levy, L. L. Psychological interpretation. Holt, Rinehart, and Winston, Inc., 1963.

Lorion, R. P. Socio-economic status and traditional approaches reconsidered. Psychological Bulletin, 1973, 79, 263-270.

Lorion, R. P. Patient and therapist variables in the treatment of low-income patients. Psychological Bulletin, 1974, 81, 344-354.

Luborsky, L., Chandler, M., Auerbach, A. H., Cohen, J., & Bachrach, H. M. Factors influencing the outcome of psychotherapy: A review of quantitative research. Psychological Bulletin, 1971, 75, 145-185.

Mahoney, M. J. Personal science: A cognitive learning therapy. In A. Ellis & R. Grieger (Eds.), Handbook of rational psychotherapy. New York: Springer, 1977.

Marston, A., & Feldman, S. Toward the use of self-control in behavior modification. Journal of Consulting and Clinical Psychology, 1972, 39(3), 429-433.

Meichenbaum, D., & Genest, M. Cognitive behavioral modification: An integration of cognitive and behavioral methods. In F. Kanfer & A. Goldstein (Eds.), Helping people change. New York: Pergamon Press, 1980.

Meltzoff, J. E., & Kornreich, M. Research in psychotherapy. New York: Atherton Press, 1970.

Moos, R. H. Social-ecological perspectives on health. In G. Stone, F. Cohen, & N. Adler (Eds.), Health psychology. San Francisco: Jossey-Bass Publishers, 1979.

Munjack, D. J., & Oziel, L. J. Resistance in the behavioral treatment of sexual dysfunctions. Journal of Sex and Marital Therapy, 1978, 4(2), 122-138.

Overall, B., & Aronson, H. Expectations of psychotherapy in lower socioeconomic class patients. American Journal of Orthopsychiatry, 1962, 32, 271-272.

Pearlin, L., Menaghan, E., Leiberman, M., & Mullan, J. The stress process. Journal of Health and Social Behavior, 1981, 22, 337-356.

Perri, M., & Richards, C. S. The investigation of naturally occurring episodes of self-control behavior. Journal of Counseling Psychology, 1977, 24(3), 178-183.

Pyszczynski, T. Cognitive strategies for coping with undertain outcomes. Journal of Research in Personality, 1982, 16, 386-399.

Rosenthal, D., & Frank, J. D. The fate of psychiatric outpatients assigned to psychotherapy. Journal of Nervous and Mental Disease, 1958, 127, 330-334.

Rozensky, R. H., & Bellack, A. S. Behavior change and individual differences in self control. Behavior Research and Therapy, 1974, 12, 267-268.

Schachter, S. Recidivism and self-cure of smoking and obesity. American Psychologist, 1982, 37, 436-444.

Schaefer, C., Coyne, J., & Lazarus, R. L. The health-related functions of social support. Journal of Behavioral Medicine, 1981, 4(4), 381-406.

Schofield, W. Psychotherapy: The purchase of friendship. Englewood Cliffs, N.J.: Prenti-e-Hall, 1964.

Spiegler, M. D., Liebert, R. M., McMains, M. J., & Fernandez, L. E. Experimental development of a modeling treatment to extinguish persistent avoidance behavior. In R. D. Rubin & C. M. Franks (Eds.), Advances in behavior therapy. New York: Academic Press, 1969.

Stuart, R. Helping couples change. New York: Guilford Press, 1980.

Tinsley, H. E. A., Workman, K. R., & Kass, R. A. Factor analysis of the domain of client expectancies about counseling. Journal of Counseling Psychology, 1980, 27, 561-570.

Turkat, D., & Meyer, V. The behavior-analytic approach. In P. L. Wachtel (Ed.), Resistance: Psychodynamics and behavioral approaches. New York: Plenum Press, 1982.

Zucker, H. Problems of psychotherapy. New York: Free Press, 1967.